



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

VISTA MEDICAL CENTER HOSPITAL

Respondent Name

AMERICAN CASUALTY CO OF READING PA

MFDR Tracking Number

M4-05-5307-02

Carrier's Austin Representative

Box Number 47

MFDR Date Received

MARCH 16, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated April 8, 2005: "...if the total audited charges for the *entire admission* are below \$40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges for the *entire admission* are at or above \$40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF)."

Requestor's Supplemental Position Summary Dated November 24, 2014: "Please allow this letter to serve as a supplemental statement to Vista Medical Center Hospital's (VMCH) originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment... The medical records on file with MDR show this admission to be a complex partial lumbar laminectomy at L5 and S1. This complex spine surgery is unusually extensive for at least the following reasons...The medical and billing records on file with MDR also show that this admission was unusually costly for at least the following reasons."

Amount in Dispute: \$31,758.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 12, 2005: "Although Provider's grossly inflated charges exceed \$40,000, there is no evidence that the services provided were unusually extensive and costly. Specifically, there is no evidence that the patient had co-morbidities or complications that required unusually extensive services or that any such services were unusually costly."

Respondent's Supplemental Position Summary Dated November 24, 2014: "The medical records do not demonstrate that this was an outlier case. There is no evidence that Requestor provided in this case that would not normally be provided to someone receiving this same type of surgery and that were unusually extensive and unusually costly. Furthermore, Requestor has not identified any specific services it contends were unusually extensive and it has not established the unusual cost of those services. In short, Requestor has not met its burden of proof. For these reasons, the Division should not approve reimbursement under the stop-loss exception but should affirm that reimbursement should be pursuant to the standard per diem method."

Response Submitted by: Stone Loughlin & Swanson, LLP.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 15, 2004 through April 17, 2004	Inpatient Hospital Services	\$31,758.51	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
- 28 Texas Administrative Code Rule §134.600, effective March 14, 2004 requires preauthorization for non-emergency inpatient hospitalizations.
- 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
- Texas Labor Code §413.014 sets out the policy and guideline regarding preauthorization.
- Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - G-Unbundling.
 - 855-013-Payment denied – The service is included in the global value of another billed procedure.
 - M-No MAR.
 - 855-016-Payment recommended at fair and reasonable rate \$1,118.00.
 - N-Not appropriately documented.
 - 880-134-Charge denied due to lack of sufficient documentation of services rendered 100%.
 - O-Denial after reconsideration.
 - 920-002-In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
- Dispute M4-05-5307 History
 - Dispute was originally decided on January 15, 2009.
 - The original dispute decision was appealed to the State Office of Administrative Hearings (SOAH).
 - SOAH issued a decision remanding the dispute to the Division on August 27, 2009 docket number 454-09-2357.M4.
 - As a result of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
 - M4-05-5307-02 is hereby reviewed.

Issues

- Did the audited charges exceed \$40,000.00?
- Did the admission in dispute involve unusually extensive services?
- Did the admission in dispute involve unusually costly services?
- Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for

reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the requestor and respondent in this dispute supplemented the original MDR submissions. The Division received supplemental positions as noted above. Positions were exchanged among the parties as appropriate. Documentation filed by the requestor and respondent to date is considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals’ November 13, 2008 opinion, the Division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold...” In that same opinion, the Third Court of Appeals states that the stop loss exception “...was meant to apply on a case-by-case basis in relatively few cases.” 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, 28 Texas Administrative Code §134.401(c)(6)(A)(v) states that “Audited charges are those charges which remain after a bill review by the insurance carrier has been performed.” Review of the explanation of benefits issued by the respondent finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore, the audited charges equal \$43535.35. The Division concludes that the total audited charges exceed \$40,000.00.
2. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The Third Court of Appeals’ November 13, 2008 opinion states that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services” and further states that “independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” In its position, the requestor states:

The medical records on file with MDR show this admission to be a complex lumbar fusion. This complex spine surgery is unusually extensive for the following reasons:

- This type of surgery is unusually extensive when compared to all surgeries performed on workers’ compensation patients in that only 19% of such surgeries involved operations on the spine;

The requestor’s categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor’s position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals’ November 13, 2008 opinion affirmed this, stating “The rule further states that independent reimbursement under the Stop-Loss Exception will be ‘allowed on a case-by-case basis.’ *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestor’s position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

3. In regards to whether the services were unusually costly, the Third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor’s supplemental position statement asserts that:

The medical and billing records on file with MDR also show that this admission was unusually costly for at least the following reasons:

- The median charge for all workers’ compensation inpatient surgeries is \$23,187; the median charge for workers’ compensation surgeries of this type is \$39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the \$40,000 stop-loss threshold;

Therefore, additional reimbursement should be ordered under the stop-loss exception.

The requestor asserts that because the **billed charges** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the **costs** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the Division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed \$40,000. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to similar spinal surgery services or admissions.

4. For the reasons stated above, the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) subtitled *Standard Per Diem Amount* and §134.401(c)(4) subtitled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - On April 7, 2004, the respondent's representative, Concentra Integrated Services, Inc., gave preauthorization approval for a one day inpatient hospital stay. 28 Texas Administrative Code §134.600(i)(1) states "The health care requiring concurrent review for an extension for previously approved services includes: inpatient length of stay." The SOAH Remand Order found that the Division properly raised the preauthorization issue in the original decision in accordance with Texas Labor Code §413.014(b) and (c).
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was two days; however, documentation supports that the Carrier pre-authorized a length of stay of one day in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is \$1,118.00 for the one authorized day.
 - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed \$299.00 for revenue code 391-Blood/Storage Processing. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
 - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed \$302.85/unit for Thrombin 5,000 units. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended.

The Division concludes that the total allowable for this admission is \$1,118.00. The respondent issued payment in the amount of \$1,118.00. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	02/02/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.